

WHO DO I CALL?



Directions: Using the following scenario, decide whom you would call and what you would say.

- You are in the kitchen cooking lunch. You have your back to Margaret. Margaret says that she is going into the family room to watch TV. You hear her fall and start to scream.
- You immediately run to her side. You find her lying on the floor in the family room, clutching her leg and screaming. Margaret is unable to get up from the floor.

• **Who would you call?**

• **Who you are:**

• **Where you are:**

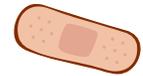
• **What has happened?**

• **When it happened:**

DSP should refer to the homes Emergency Numbers and Medical Protocols to complete



WHAT WOULD YOU DO?



For each sign or symptom listed in the left column, decide if you should respond by calling 911, placing an urgent call to the doctor, or providing routine treatment at home. Check the appropriate box on the right columns.



Sign or Symptom

Your Response

	Urgent		Routine	
	911	Dr. Call	Dr. Call	Treatment
	Onset of fever of 101 degrees or higher	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
New or sudden onset of incontinence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rash lasting several days or getting worse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding that can't be controlled	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Severe sore throat/difficulty swallowing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Infection at injury site	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleeping most of the day; unusual difficulty in arousing; unusual fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Scratching/holding one or both ears	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Holding abdomen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea or vomiting lasting more than four hours	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A seizure lasting five minutes or continuous seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Paralysis, numbness, confusion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Onset of limping, inability to walk, or difficulty in movement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mosquito bite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trouble breathing or is breathing in a strange way	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Visible swelling with doctor's order to elevate the leg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Minor cut	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is or becomes unconscious not related to a seizure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
No pulse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Any evidence of pain or discomfort	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain or pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Severe injuries, such as broken bones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Choking (not breathing and not coughing)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Injuries to the head, neck, or back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has gone into shock	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

TEST YOUR UNDERSTANDING DESCRIPTIVE VERSUS EVALUATIVE

Read each of the statements below and decide whether it is DESCRIPTIVE (D) OR EVALUATIVE (E). Record your answers by putting a (D) or an (E) next to the appropriate number.

	(D) or (E)	Statements
1.		Louise is withdrawn.
2.		Louise would not leave her bedroom until after breakfast.
3.		John cut himself with a knife.
4.		John is suicidal.
5.		Gary falls down at least once a day.
6.		Gary has brain damage.
7.		Harry is very motivated.
8.		Harry works at least ten hours a day.
9.		George finishes his work assignments every day.
10.		Mary shuffles her feet when she walks.
11.		Joe is a behavior problem.
12.		Jane seems happy.
13.		Larry yells and screams at others.
14.		Fred is having another temper tantrum today.
15.		Ruth appears to be angry.